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Global health partnerships, governance, and sovereign responsibility in western Kenya

[rh]Partnerships and sovereign responsibility

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[ab]The delivery of resources to citizens in the global South is increasingly managed through international partnerships. As systems of plural governance, such arrangements are characterized by alignments, accommodations, and conflicts between partners' respective interests. This article focuses on partnerships between the Kenyan government and organizations funded by PEPFAR (the President's Fund for AIDS Relief), drawing on fieldwork with Kenyan health managers. Partnerships were based on a separation between the ability to provide resources and the right to administer them. For Kenyans, partnerships animated a politics of sovereign responsibility in which they often felt a deep sense of managerial disenfranchisement. For their foreign collaborators, partnership relations legitimized the interventions they organized. This politics of sovereign responsibility reconfigured the importance of the state on the basis of its role in delivering resources within global relations of inequality. [*global health, PEPFAR, HIV/AIDS, governance, partnership, sovereign responsibility, the state, Kenya*]

[ep]We don't want and never talk about "our PEPFAR program" and we refer to the clinics as "Ministry of Health clinics that USMMR supports."

[epc]—Staff member, USMMR

[ep]Of late the area of HIV has attracted many interested parties. Everybody wants to be in that field and everybody wants to show what is happening. Nyanza [Province] happens to have very

many partners and these partners are also looking for stakes. So because of that there has been some conflict of interest.

[epc]—Ministry of Public Health and Sanitation employee[1]

[dc]On a warm May day in 2011, the leader of a District Health Management Team in western Kenya met with a junior employee of the largest organization responsible for supporting HIV care and treatment in the district. The meeting was strained. The district medical officer was concerned because the organization had purchased bicycles for community health workers with HIV/AIDS funds, but the managerial team had only been informed of this initiative when they were asked to appear alongside the community health workers in photographs as grateful recipients. Sitting behind a large desk, the district medical officer presided over a cramped office in a fairly dilapidated building that had been converted from former staff accommodation. In front of his desk stretched a long table surrounded by chairs, filling a room that was otherwise empty except for a white board with health indicators written on it, leaning against the wall in one corner. I sat at the table, alongside senior members of the management team. The district medical officer interrogated the young male employee of the partner organization, "How were you donating bicycles and all procurements are supposed to come through my office?" he demanded.

The organization that employed this young man was the U.S. Military Medical Research Foundation (USMMR).[2] Funded by PEPFAR (the President's Fund for AIDS Relief), USMMR supported the delivery of HIV care and treatment under the umbrella of a larger program of clinical research managed indirectly by the U.S. Department of Defense (DOD).[3] USMMR worked from offices in a compound situated directly opposite those of the government-run district hospital. In this article, I draw on extended participant-observation carried out "on the

government side," as my research participants put it, and a more limited amount of interview material collected from some of the PEPFAR-funded employees who worked "on the other side." Both practically and symbolically, this spatial organization was one that appeared to render USMMR close to its Kenyan government counterparts. Partners.

During approximately eight months of ethnographic fieldwork with this group of midlevel health managers, I observed many such meetings. The District Health Management Team were responsible for delivering health care across a rural district of approximately 120 thousand inhabitants,[4] and in doing so they collaborated with many different organizations that they referred to as their "partners." Partner organizations supported health interventions that ranged from building latrines and promoting hand washing to the purchase of computers and medical equipment. In some cases, these organizations paid the salaries of health workers.

For members of the managerial team with whom I worked as a researcher, the term *partnership* carried associations of reciprocity and equality. However, partnership relations were also marked by large disparities in terms of the availability of funds and resources. The egalitarianism implied by partnership was counterpoised by substantial differentials of power (cf. Crane 2010; Mercer 2003; Mohan 2002). In Kenyan health centers and hospitals, partnership is visible and it is branded. Equipment and furniture are stickered with the increasingly familiar logos of the international organizations that purchased these items. This slick, state-of-the-art commercialization heightens a sense of differentiation between what is perceived as local and what is perceived as international. For both staff and service users, visible material distinctions contributed to an imagined lack of capacity of the Kenyan state, whose institutions remain decorated by the hand-painted signs of previous eras and the stencil craft of local artists. Outside hospitals and health facilities, the money and resources that these organizations have made

available in the region have also had a dramatic impact on local economies, made visible partly through items like bicycles donated to community volunteers but more dramatically in the plethora of signboards for NGOs and community groups that line the roads of even the smallest towns and in a construction boom in hotels and conference centers (see also Prince 2012, 2013).

After the meeting about the bicycles, a rumor circulated that their procurement had been irregular: “Those people are swimming in money,” someone complained, underlining suspicions of improper expenditure of HIV funds by USMMR. Vast inequalities of resource availability created pockets of plenty within organizations accustomed to managing economies of absence. In this context, rumors of the misuse of resources could easily gain traction.

In this article, I draw on the specific example of the provision of HIV care and treatment in western Kenya to analyze the delivery of resources through such partnerships. This case study sheds light on a dimension of sovereignty that has been underexplored in anthropology, that of sovereign responsibility. Sovereign responsibility is the space that lies between the sovereign and the citizen, where states and nongovernmental and foreign governmental organizations organize the transfer of resources. A field of practice that is partly marked by a distinct set of political concerns linked to resource allocation and delivery, sovereign responsibility is also in other respects a hybrid of sovereignty and citizenship as classically understood in anthropology. The utility of the concept of sovereign responsibility is particularly apparent in its capacity to theorize forms of extended and pluralistic governance.

Following a brief overview of partnerships in global health, I consider the concept of sovereign responsibility in more detail, emphasizing the centrality of resource management to this field of governance. I next explore the politics of partnership and resource distribution through the specific case of the partnership between USMMR and Kenyan government health

managers. Detailed ethnographic description depicts how partners on both sides of this relationship struggled to manage different visions of responsibility across vast organizational inequalities. I then turn to meetings as key sites for the performance and practice of partnership relationships. I show how meetings were opportunities for delineating the forms of difference and collaboration that made partnerships possible, and I explore what happened in a case in which these relationships broke down. Making an extended comparison with Max Gluckman's (1940) analysis of an early development project in southern Africa, I show the fragile way partnerships were maintained through the copresence of modes of integration and forms of difference. I draw on these ethnographic insights in a final discussion about the changing forms of statehood that are emerging through this new politics of sovereign responsibility.

[h1]Global health governance

Many foreign agencies in Kenya and elsewhere now work in the manner of USSMR and situate their offices alongside or even within government buildings. They seek continual access to senior government officials and aim to physically demonstrate the alignment of their interests with those of the state. These changes highlight the increasing predominance of pluralistic forms of governance in many developmental sectors. Within new regimes of global health, such relationships are also characterized by increases in funding, the emergence of powerful actors, and the growing influence of wealthy funding bodies (e.g., Brown et al. 2006; Cohen 2006; Crane 2013). Governance practices, including administrative procedures and rationales for the distribution of resources, are changing as health resources travel along these new pathways. International agencies and foreign governments are increasingly involved in the delivery of health care in areas that were once the domain of the nation-state, often working through state infrastructure to strengthen national health systems and deliver improved health services.

The health managers whose work I describe in this article were involved in partner relationships that were based primarily on a separation between the ability to provide resources and the right to deliver them; external organizations provided resources and "supported" programs that the Kenyan government "implemented." However, these mainly U.S.-funded organizations also had a large stake in successful implementation. They wanted to "see results" and to measure the value of their contributions. These differing interests and spheres of activity were at times complementary. At other times, the partial separation of responsibility for resource provision and resource management resulted in struggles over sovereignty.

Sovereign power, Giorgio Agamben (1998:15–19) argues, is achieved through the paradox that the sovereign can stand outside the very system from which its power derives.[5] Agamben sees sovereign power as being achieved through the "taking of the outside" (1998:19), a process by which the sovereign marks out a sphere of influence and control that it can act on. Cases of pluralistic governance complicate this process. Governance through partnerships of the kind described in this article is shaped by competing and intersecting forms of sovereignty, manifested through variegated attempts to "take the outside" and formed through the juxtaposition of different kinds of managerial goals and prerogatives within the same administrative space. In this article, I explore ethnographically how the practice of sharing responsibility to provide health services reconfigured boundaries around managerial entitlement, and I use this analysis to develop anthropological understandings of sovereignty as a field of power and social practice. In the partner relationships I observed, the presence of many different actors involved in resource delivery meant that governmental and sovereign power had become partly divorced from the territorial jurisdiction of the state. However, at the same time, the institutional legitimacy of the nation-state was reinforced (cf. Chalfin 2010; Sassen 1996). Actors

on both sides of partnerships asserted the importance of the state, even when the state was unable to provide resources. The ethnographic material presented here underlines the importance of moving beyond theorizations of governance and states in Africa based on ideas of incapacity and failure (Brown n.d.). What is at issue here is not a "retreating" or "vanishing" state but, rather, new forms of statehood and governance that are emerging as a result of an increase in resource delivery and the involvement of an expanding set of actors in the provision of services to Kenyan citizens. In focusing on these processes, this article contributes to the development of new conceptualizations of the jurisdiction and power of the state in the context of transnational forms of governance (Ferguson and Gupta 2002; Ong 2006; Randeria 2007) and documents the mobility and political hegemony of global institutions such as "partnerships" while also attending to the specific ways these formations play out in different social contexts (Ong and Collier 2006; Tsing 2005).

[h1]Sovereign and citizen

The material and technical enactment of boundaries aligned to spaces of sovereignty has long held the attention of anthropologists and other social theorists (e.g., Anderson 1983; Arendt 1958:194–195; Foucault 1977:195–228, 2002, 2008). Some anthropologists who analyze the field of power that Michel Foucault (2002) termed "governmentality" have explored relationships between (sovereign) power and practices that mark out the boundaries of the governable (Li 2007; Mitchell 2002; Scott 1998; Strathern 2000; Watts 2003). Others have observed that, although related to the boundaries of the nation-state, governmental power can be distributed across sites that extend beyond it (Ferguson and Gupta 2002; Hansen and Stepptuat 2005; Ong 1999, 2006; Trouillot 2001). While this literature has focused on the production of spaces of sovereign influence and intervention, another set of literature on sovereignty has

studied the construction of active subjectivities within contemporary—usually neoliberal—governmental contexts (e.g., Biehl et al. 2007; Rose 1999a, 1999b). This work has focused on formations of citizenship as the basis of claims made to the state and other organizations. Particularly relevant to the concerns elaborated in this article are recent discussions by anthropologists interested in the philanthropic rationalities that underpin humanitarianism. These writers have explored how humanitarian interventions involving the delivery of resources are based on claims that differ from those established through conventional forms of citizenship. In particular, theorists have drawn attention to a narrowing of rights and entitlements that center on what Agamben (1998) termed "bare life" rather than on broader conceptualizations of welfare (Comaroff 2007; Fassin 2007; Petryna 2002; Redfield 2005). This literature has explored cases of people making claims to resources on the basis of their entitlement to survive rather than other kinds of rights, such as the right to work, have a family life, or join political associations (Nguyen 2005, 2010; Ticktin 2006). Such understandings of rights have been central to the treatment demands of HIV/AIDS activists (Robins 2004, 2006) and have informed international responses to the HIV/AIDS pandemic.

An ethnographic and theoretical space, however, exists in the terrain between sovereignty, understood as the right to define an area of intervention, and citizenship, understood as the right to receive certain kinds of resources. This is the space of sovereign responsibility. The responsibility to deliver resources and serve populations is what lies between sovereignty and citizenship in the sense that it draws on the sovereign entitlement to define and intervene in a governmental field but is at the same time shaped by understandings of the entitlements of citizens to receive particular kinds of resources from the state or other organizational bodies. In the context I consider here, the successful organization of sovereign responsibility was central to

the performance of sovereign power. It was only when sovereign responsibility appeared to be undermined that conflicts emerged.

[h1]Negotiating sovereign responsibility in a site of plural governance

[ep]Organized domination requires control of … the material implements of administration.

[epc]—Max Weber, "Politics as a Vocation"

Later in the day following the meeting with which I open this article, Samuel Otieno,[6] a senior member of the management team, approached me and told me that he had "become aware of an issue" at a dispensary located a short distance from the district hospital and asked if I would like to accompany him there. En route to the dispensary, Otieno, who had also been present at the exchange about the bicycles, complained vehemently that USMMR were behaving as though they, rather than the Kenyan government, were the implementing partner for HIV/AIDS treatment, when their role should have been primarily to support the Ministry of Health! He protested that USMMR did not follow government protocol and had even been known to tell staff at health facilities not to bother sending their reports to the Ministry of Health and, instead, to report back directly to USMMR. Like many other members of the District Health Management Team, Otieno often struggled in working alongside USMMR, experiencing a deep sense of managerial disenfranchisement in his engagements with partner organizations. "Those people are running a parallel ministry!" he complained.

Arriving at the health facility, Otieno made brief observations of work ongoing in the outpatient clinic and HIV support center. Then he convened a meeting of all staff members. Prior to the meeting, Otieno had asked each of us to introduce ourselves and also state who we were employed by. Those who worked in the health facility introduced themselves as clinical officers, nurses, and community health workers. Some said that they were employed by PEPFAR or

USMMR, and others said that they worked for the Ministry of Public Health and Sanitation or for the government of Kenya. Then Otieno probed further: "And who is your line manager?" Around half named the same member of the USMMR team who had earlier in the day been rebuked by the district medical officer for the bicycle incident; the others named the clinician in charge of the facility.

Otieno paused for dramatic effect then declared,

> [ex]So I am wondering what is going on here because I have heard there are some people employed by PEPFAR! What I wanted to bring across is that as soon as you enter the gate of this dispensary there is nobody here called PEPFAR! Clients don't choose which they want to have when they come here! So don't wait to see the boundary. Everything here is Government of Kenya. PEPFAR–USMMR are only meeting the gaps of the ministry, one of which is pay, but you are working for the government so I don't want someone saying now they have finished with their PEPFAR clients and now they are going to sit under a tree. If that is happening it should stop with immediate effect. ... I don't want to hear that in this dispensary there are PEPFAR people and government people. Let us work as one team when people come for service ... Do we understand one another?

At this meeting, Otieno articulated his right as a government employee and representative of the Kenyan state to manage decisions around HIV care and oversee the integration of HIV services into other forms of health care delivery, just as the district medical officer had earlier in the day articulated his right to manage procurement processes that took place in the district. As fieldwork progressed, Otieno regularly drew me into conversations and situations in which I could witness what he viewed as struggles to hold onto managerial power. Although Otieno's

performance at the health facility was one of the more striking examples I observed during fieldwork, similar attempts by members of the District Health Management Team to mark the boundaries of sovereign responsibility were a common feature of working life. Memoranda were sent down from the higher echelons of the ministry emphasizing that partner organizations were not permitted to work in the province without the authority of the provincial medical officer. When addressing groups of health workers in meetings, the leader of the District Health Management Team similarly emphasized that external organizations were not permitted to carry out managerial supervisions without a member of the team being present and that no research or any other kind of intervention was permitted in health facilities without a letter of authorization from his office.

For the government employees with whom I worked, HIV care was one of several services that they were entrusted—as employees of the Kenyan state—to provide the Kenyan citizenry. As government managers, the District Health Management Team viewed themselves as entitled to oversee this provision and as responsible for ensuring that the varied interventions of the many different partners working in the district best met the needs of Kenyan people. For these health workers, foreign donations were viewed as constituting part of what has been described as the "national cake,"[7] precious resources that should be delivered to Kenyan people under their guidance (see also Høg 2014). In this formulation, the right to take on responsibility for the delivery of resources and to "see like a state" (Scott 1998) was divorced from the ability of the state to provide such services. Although grateful for the financial and material support of outsiders, health workers experienced the responsibility to organize the provision of services as both a managerial and a sovereign right. Nevertheless, working through partnerships meant confronting other kinds of sovereign and managerial rights. The most significant of the

partnerships through which Otieno and his colleagues delivered health care were those funded by PEPFAR.

[h1]The President's Emergency Fund for AIDS Relief

In Nyanza Province, where my fieldwork took place, the majority of HIV/AIDS care and treatment is funded by PEPFAR. PEPFAR interventions can be considered largely typical of contemporary forms of health and development initiatives that are organized through the institution of the "partnership." However, PEPFAR is also atypical in its size and scope, and the extent to which the sovereign interests of the external partner—the U.S. government—are visible through its interventions.

Launching the intervention in his 2003 State of the Union address, George W. Bush described PEPFAR as "a work of mercy beyond all current international efforts to help the people of Africa." Humanitarianism has many different modalities and PEPFAR has had its own distinct trajectory and "habitus of the gift" (cf. Redfield and Bornstein 2010:11). At its inception, it was described as the "largest ever global health initiative dedicated to a single disease" (Sessions n.d.:1); 55 percent of PEPFAR's initial $15 billion budget was dedicated to the therapeutic care of people with HIV/AIDS, with 75 percent of this amount earmarked for the purchase and distribution of antiretroviral therapy.[8] However, PEPFAR emerged from entanglements with a range of political, humanitarian, and religious influences and is a form of humanitarianism strongly tied to an image of the United States as a powerful, sovereign actor in an unequal and diseased world. Initiated within the context of an emergent biopolitics that ties international welfare provision to issues of security affecting the United States (e.g., Elbe 2010; Ingram 2010; King 2002; Lakoff 2010), from the outset, PEPFAR was profoundly shaped by U.S. domestic politics (Dietrich 2007; Ingram 2010). Perhaps most controversially, during the

Bush presidency the influence of evangelical Christians shaped prevention policy and the delivery of care and treatment programs, among other ways, through a programmatic bias toward funding faith-based organizations and against the promotion of condoms (Dietrich 2007; Epstein 2007).

In western Kenya, the influence of PEPFAR funding became heightened from mid-2006 onward, when dedicated Patient Support Centers in larger government hospitals in the province began to provide free antiretroviral therapy to those who met eligibility criteria and the roll-out of HIV treatment programs to smaller health facilities was underway (Brown 2010). In the ensuing years, as the provision of HIV care and treatment has extended across the province, people in western Kenya have often experienced PEPFAR as an intervention bordering on the miraculous in terms of the resources it has made available. Health workers and patients alike praise the tangible commitment of successive U.S. administrations to improving health outcomes for people in the region. This is particularly true for those who experienced the trauma of AIDS during the pre-PEPFAR era, when, as some people recalled, "everyone was dying." During the worst years of the epidemic, an HIV diagnosis was widely experienced as a death sentence, and communities struggled deeply with the resultant social, economic, and emotional devastation (cf. Geissler and Prince 2010).

In recent years, health facilities across the region have become notably better resourced in terms of equipment and personnel, primarily as a result of the financial and administrative influence of PEPFAR. In these senses, PEPFAR interventions have been truly life changing. At the same time, despite genuine gratitude for the interventions of the U.S. government, there are also feelings of disquiet and unease relating to these gifts. The administration of PEPFAR resources in Nyanza takes place through a plethora of different contracted organizations, each

with its own plush office and fleet of four-wheel-drive vehicles. The material affluence of these organizations stands in stark contrast to the still woefully underfunded Ministries of Health that must work in partnership with them in the delivery of HIV care. Concerns relating to these feelings of disjuncture are less easily voiced than are sentiments of gratitude, particularly in public, but are equally important for understanding the effects of this funding.

PEPFAR funds move along what are primarily unilateral pathways, and expressions of the sovereign power of the U.S. government are a key characteristic of in-country organization. As in other PEPFAR-supported countries, in Kenya funding is directed through a bilateral agreement with the Kenyan government, but administration remains primarily with the technical agencies that manage U.S. government overseas assistance.[9] At the time of fieldwork, funds in Nyanza Province were streamed from a national office,[10] through three different U.S. implementing agencies: USAID, the CDC, and the DOD. These agencies in turn worked through "local" organizations (some of which had originally been founded by other U.S. organizations). In a highly complex system, some implementing agencies ran programs under the auspices of partnerships with Kenyan organizations but functioned largely independently from the organizations with whom they collaborated. Some agencies contracted out their care and treatment programs to still other organizations. These smaller-scale agencies competed with one another to meet targets for HIV testing and enrollment of patients in support programs and to prove that they offered value for money. In most cases, HIV care and treatment was delivered through local-level partnerships with the Ministry of Health based within Kenyan government health facilities. These treatment programs were run on a day-to-day basis by staff whose salaries were paid in some cases by the Kenyan government and in others by PEPFAR. The result was an

intricate system of tiered partnerships; U.S. implementing agencies partnered with "local" organizations, which in turn partnered with the Ministries of Health.

The District Health Management Team with whom I carried out fieldwork worked primarily with USMMR but also through a second organization, the International AIDS Partnership.[11] This organization outwardly resembled an NGO, and its activities extended into broad-based public health interventions and community projects. However, it was not technically an NGO but, rather, an international consortium—a "partnership" itself—between university medical schools in the United States and in Kenya. This was a common form for many of the "local" implementing organizations through which PEPFAR worked (e.g., see Crane 2010, 2011; Quigley 2009).

Beyond the new administrative forms that emerged through the partnership response to HIV, the kinds of organizational configurations involved also supported the convergence of health governance and clinical research, a form of pharmaceutical experimentality (cf. Crane 2013; Geissler and Molyneux 2011; Petryna 2009). In western Kenya, PEPFAR interventions are increasingly taking place alongside or in the wake of medical research. For example, USMMR worked at the intersections of medical research and health care delivery. It began its PEPFAR program in 2006 partly out of a desire to streamline HIV care and treatment services with large ongoing clinical research and a nascent demographic surveillance system and because access to HIV-positive populations through treatment provision could provide a useful pool of future clinical research participants. Furthermore, as Johanna Crane has described for Uganda (e.g., 2013), across Nyanza, many of the "local" organizations delivering PEPFAR-funded care and treatment programs with whom the U.S. implementing agencies collaborated had been created under the auspices of clinical research interventions led by U.S. medical schools. Some of these

organizations also provided "clinical tourism" (Wendland 2012) opportunities for U.S. medical students interested in learning about global health. Meanwhile, U.S. companies were often favored during procurement procedures for PEPFAR, especially for widely dispensed items such as the high-protein flour that was given to severely underweight, HIV-positive adults and children.

Although their motivations were in many ways irreproachable, these organizations have over the years carved up responsibility for delivering care and treatment services in a manner that, at worst, recalls colonial-era scrambles for power in the continent. PEPFAR is enacted as a heroic endeavor that celebrates "the" U.S. president and nation as it makes a difference in an unequal world. The very reference to the president, and the assumption that "we" all know which president is being referred to (cf. Billig 1995), attests clearly to the ways PEPFAR itself seeks to demonstrate the sovereign power and benevolence of the United States. Yet, on the ground, the resulting material and organizational mêlée—and the emergence of aid(s) economies marked by new forms of inequality—at times appears hugely dysfunctional and worrisome.

[h1]Partnership: Resources and responsibility

[ep]Can two [PEPFAR] partners really work alongside one another in one health facility? No—that one is like having two wives in the same house!

[epc]—Exchange between two district health managers

Despite PEPFAR's unilateral organizational tendencies, because HIV care and treatment was directed through Kenyan government structures, the institution of "partnership" was especially prominent at the level of implementation. Partnership has become a dominant modality for the bilateral engagements of international donors and aid agencies with governments of the global South (Craig and Porter 2006; Gerrets 2010; Gould 2005). Partnership relations of different

kinds similarly underpin organizational architectures for global health responses to HIV/AIDS (Putzel 2004). In Kenya as elsewhere, partnership is also a central pillar of grassroots development work. Community groups and small NGOs work through partnerships with "local communities" and "key stakeholders" and value such relationships as an indication of beneficiary "ownership." As an antidote to the perceived overprescriptive aid interventions of the past, its proponents argue, partnership reflects a new, more collaborative mode of engagement between donor and recipient through relations that recast poor countries and aid recipients as actors "in strategies determined and 'owned' by recipients themselves" (Abrahamsen 2004:1453; see also Esser 2014). However, the associations of reciprocity and equality engendered by the term *partnership* can obscure large discrepancies of power between the parties involved (Crane 2010; Mercer 2003; Mohan 2002). Partners may "own" strategies of implementation, but it is far from clear that they "own" the broader terms of this engagement.

For the District Health Management Team, the greatest challenge of partnership lay in marking out a relationship between the state and its citizens through processes of resource management in a context of huge economic disparity between government and partner organizations. Recall that in his outburst at the dispensary, Otieno announced that "PEPFAR is only meeting the gaps of the ministry, one of which is pay." But staff salary is a significant gap in governmental capacity and was typical of the disproportionate distribution of resources between partner organizations and their Kenyan counterparts in their daily work. Both the managerial team and employees of partner organizations spoke of a division of labor between the work of "support," which fell to partners, and "implementation," the responsibility of the Ministry of Health, a terminology that could be seen as an attempt to rationalize these disparities of resources and power. The management team's Annual Operational Plan described in some

detail engagements with partners down to the level of workshops and supervision visits, activities funded almost entirely by partner organizations. However, the irony—and discomfort—of receiving such extensive "support" from organizations that were often better resourced than the government was not lost on these health managers. One informant, surveying the office during a tea break, joked about how partners had paid for everything there, from the furniture and the team's mobile phones to the Internet connection and the stationery. Even the tea that we were drinking was paid for by partners! Laughing, she reflected on the irony of sitting in a government office where nothing was government issue.

These differences were most striking in the case of the PEPFAR-funded partner USSMR, whose offices were close to those of the district hospital, engendering a permanent comparison of the two organizations during the process of everyday working life. The USMMR compound was tightly guarded by a private security firm, contained offices with desktop computers for all staff, and had a large air-conditioned pharmacy. Across the road, many of the District Health Management Team worked in offices without functioning electricity. Unlike the District Health Management Team, who mainly relied on public transport to travel to work, many staff at USMMR drove to work in private vehicles. They received higher salaries than their Ministry of Health counterparts, and some pursued educational qualifications at world-renowned international institutions rather than the local university attended by some members of the district team.

Furthermore, staffing levels at the two organizations were highly divergent. Only one member of the District Health Management Team was dedicated to HIV/AIDS work, the district AIDS officer (DASCO). On "the other side," a team of six people (a medical doctor, clinical officer, pharmacist, lab technologist, nutritionist–counselor, and community liaison officer) and

two administrators focused on HIV/AIDS. The District Health Management Team had two vehicles that they used for their everyday work of managing all areas of public health in the district; both were seemingly kept running through a combination of clever budgeting, judicious use of a highly limited petrol supply, and the grace of God. On "the other side," a large number of modern four-wheel-drive vehicles constantly moved in and out of the compound.

Although there was often friction between partners, not all interactions were difficult or strained, and relationships changed over time. One PEPFAR employee told me, "It's like a cycle, there are times you get very good DHMT [District Health Management Team], and times we get bad ones, when you get a good one you enjoy the ride!" Indeed, it was often particular individuals who jeopardized working relationships, like the young man who so offended the district medical officer by failing to follow proper procurement procedures in the purchase of bicycles for community health workers. He was unpopular among the government managers because he was thought to be lacking in the necessary expertise and professional qualifications for his role and because of suspicions that he was siphoning HIV funds for his own benefit. Many of his colleagues were highly respected by the District Health Management Team, particularly those who had previously worked for the Ministry of Health and who—it was felt—understood the challenges the team faced. "He is good, he thinks programmatically," Otieno once commented of another member of the same team.

Meanwhile, people on both sides alluded to the problematic relationships between the different partner organizations that worked in the district. For example, the clinical officer in charge of one of the largest HIV clinics in the district responded to the interview question, "What health service improvements or interventions would you like to see in the district?" with an

emphatic response that simultaneously underlined her concerns about relationships between the ministry staff and partner organizations and those among these organizations themselves,

> [ex]I want to see the partners work together! Because we have so many indicators that need to go up. We have child mortality, we have child survival, sanitation … we want them to work together so that we improve indicators. Because as of now they are not working together well ... I believe when partners are working in a District they should be … sat down with the District Health Management Team and the District Health Management Team says to them look at this look at that, instead of grumbling among themselves.

From the perspective of PEPFAR-funded organizations, however, partnership raised other kinds of issues. PEPFAR staff complained that when they called collaborative meetings, the District Health Management Team members did not attend. They argued that it was difficult to work collaboratively with a team of people who could "never be found" because they were "constantly called out of their offices" attending meetings and training courses. One PEPFAR-employed interviewee described how his attempts to expand HIV services were met by complaints by the District Health Management Team that he was trying to run these interventions without them: "[The problem is that] if you let them run it they also don't run it ... they don't follow up and people spend too much time in meetings ... and that's my major problem, one of our problems. You see for me, I have funds and we expect results. But it is such that if you do something [without them] it's a problem, and if you don't do something it's still a problem."

Torn between a desire to work collaboratively and the need to prove results, members of the USMMR team often found that they could not rely on the District Health Management Team

to prioritize their work in ways necessary to meet the goals of the PEPFAR program. Meanwhile, on the "government side," the District Health Management Team read such actions as signifying a lack of respect. And, indeed, sometimes USMMR did push ahead without properly involving their government partners. One informant complained, "This guy he called a meeting about the renovations [of a health facility] today. We told him that we could not make it because we have another meeting scheduled, but they have just gone ahead anyway."

Beyond the differential levels of material resources available on each side of the partnership, these conflicts exposed broader issues related to differing claims around responsibilities to deliver goods and services. PEPFAR organizations acted primarily through humanitarian rationalities based on a sense of moral obligation to intervene in the lives of a section of the population—those living with or at risk of HIV/AIDS—rather than the whole population, within a context of doubt about state capacity to provide services to its citizenry (cf. Lakoff 2010; Redfield 2005, 2012:157–160). Their activities played out within the broader context of a developmental rationale that has historically based understandings of the need for intervention on representations of failure and weakness (Escobar 1995; Ferguson 1990; Li 2007). Furthermore, because they were spending "American taxpayers' money," PEPFAR-funded organizations brought with them a managerial responsibility to ensure that this money was properly spent and to report back against this expenditure. In contrast, the District Health Management Team sought a broad overview of the provision of health care to all those living in the district and had to juggle their commitment to HIV care with other health priorities. Finally, and perhaps most importantly, as individuals committed to serving Kenyan people, the District Health Management Team wanted to "feel like a state" by demonstrating the sovereign right and

capacity of the Kenyan government to manage the delivery of health resources and supervise the activities of partners.

The friction (Tsing 2005) created through the juxtaposition of these different visions of responsibility raised fundamental questions of sovereignty and governance: Who had the right to act on behalf of the citizens of Kenya? How should health services be organized? Who should be in a position to oversee interventions that responded to public entitlements? Within partnerships, the answers to these questions were partial and shifting. At times, partnerships seemed to be animated most profoundly by the way tensions between governmental forms of state welfare and international humanitarianism played out within the domains of interventions. But the frictions were also more complex and nuanced than this; partnerships were further animated by the contradictions and organizational incoherencies that shaped each "side" of the partnership. Partner organizations often recruited staff who had previously worked for the Ministry of Health, blurring distinctions between the two sides, and different partner organizations bickered among themselves and competed for funding in ways that occasionally resulted in the duplication of interventions or gaps in service delivery. Sovereign responsibilities also traversed scales; they were manifest at the level of institutions and organizations but also at an individual level by employees on both sides who experienced an often-profound duty of service to Kenyan citizens.

[h1]Meetings: Performing partnership

Partnerships animated all aspects of working life. Partner organizations funded core aspects of the District Health Management Team's working activities, such as visits to health facilities for supervision. Yet meetings of various kinds were the paradigmatic expression of partnership as a governmental form. At closed meetings with representatives from partner organizations, the District Health Management Team made requests of partners to fund workshops and to fill gaps

in areas where they experienced staff and equipment shortages. Meetings thus provided the opportunity to expand partnerships and develop new avenues of support. Gaining and maintaining the support of partners through meetings was so important that it was documented as a managerial achievement in district reports, which recorded meetings that had taken place alongside lists of resources obtained from partners. Meetings could also provide a space in which to air grievances, such as concerns about managerial processes. As in other settings, for these health managers, meetings were a central part of organizational decision making and were at the heart of administrative politics (e.g., Richards and Kuper 1971; Schwartzman 1989). Meetings also unfolded in a particular form. This form was an idealized expression of how participants should relate to one another and to the tasks that befell them (cf. Graeber 2009; Morton 2014; Riles 2000). Meetings thus facilitated partnerships by delineating the respective positions and obligations of each partner and providing sites for the negotiation of complaint and conflict. Meetings also perpetuated partnership as a mode of governance by acting as sites for the ordering, expression, and management of these relationships.

Partnership relations did not correspond to a universal form. More than 12 different partner organizations worked in the district where my fieldwork took place, three of them with quite substantial influence in terms of material, organizational, and financial presence. Other partners were smaller and had a more intermittent involvement in the district. These partnerships counted—both literally and metaphorically—in very different ways.[12] The smallest partners did little more than fund the odd training course. Others regularly called the entire managerial team to meetings and were frequent visitors to their offices. Each organization had its own modus operandi and differing form of engagement with the District Health Management Team. Meetings with partners similarly took place through a variety of forms, ranging from small

consultations in the team's offices to workshops for health workers at which facilitation was shared between the District Health Management Team and partner organizations to joint collaborative meetings between the entire management team and staff of partner organizations to discuss budget settlements and intervention strategies.

Meetings also provided the opportunity to perform partnership as a successful governmental form. At meetings where health workers or outsiders were present alongside managers, both sides of partnerships were at pains to publicly emphasize their good working relationships. If the District Health Management Team forgot to invite any partners to a meeting or to thank them publicly for their support, the lapse was experienced as a major faux pas. At one stakeholders meeting, to which a major partner had been invited but (unlike other partners) had not been given a presentation slot, the district clinical officer interrupted proceedings to acknowledge the presence of attendees from the organization and thank them for their support after a rumor circulated that they were not happy about their exclusion. One of his colleagues later confided to me her embarrassment that this partner had not been properly involved in the meeting.

Meanwhile, employees of partner organizations used meetings as an opportunity to emphasize their professional experience in particular areas of health delivery and to underline that they "worked through Ministry of Health structures" and had "expertise" and "capacity." The performance of good working relations was central to the success of partnerships, and meetings provided opportunities to demonstrate respect for others and the ability to work together effectively. At the meeting I describe below, for example, one participant began a speech by stating, "I would like to say thank you to God, now we are sitting here, the International AIDS Partnership, the District Health Management Team and the staff of Kaber

hospital and we are having a dialogue. I would like to add that I am glad we are here to work as a team."

Although meetings were sites for the performance of partnership as a successful mode of governance, their possible outcomes—and the form of partnerships themselves—were often heavily circumscribed. This was notably apparent in one very large meeting I observed at Kaber hospital, called to discuss a planned expansion of HIV care and treatment activities by the International AIDS Partnership, which had been managing a large and successful HIV clinic at a hospital in the district since 2004, into three neighboring dispensaries.

All the District Health Management Team members were invited to this meeting, which was formally hosted by senior Ministry of Health staff. There was extensive discussion about the planned expansion of HIV services by participants, who sat in an arrangement typical for such meetings, one intended to spatially represent relations among the attendees as egalitarian; senior hosts of the meeting sat directly opposite their counterparts from the International AIDS Partnership, while more junior participants (including me) sat to the side and at right angles to these two groups.[13] District Health Management Team members raised questions about who would have managerial oversight, and partner representatives reassured the government health managers of their intentions to work closely with the Ministries of Health. All participants were given the opportunity to speak. During visits to the prospective sites for expansion, the mood was jovial. There was an easy rapport between the managers and the staff at the health facilities, who seemed pleased at the prospect of being able to provide expanded HIV treatment services. Discussions centered on the need to improve the physical infrastructure of the small dispensaries where the International AIDS Partnership planned to send clinicians—initially on a part-time basis—to set up HIV treatment clinics. The ministry staff entertained hopes for connection to the

electrical grid, a small incinerator, and other improvements to these dispensaries. The more sensitive dimensions of partnership arrangements, in particular the strained relationship between the two PEPFAR-funded partners who worked in the district, were avoided.

Later in the day, away from their visitors and traveling back home, the District Health Management Team members relaxed and began joking. The district AIDS officer recalled an earlier meeting at which it had been decided that the International AIDS Partnership would take over responsibility for HIV care from USMMR in these facilities on the grounds that it was geographically better positioned to deliver services. She entertained us by mimicking a USMMR member of staff protesting, "But we have capacity!" delighting in the minor fracas between the two organizations. There was a sense among the managerial team that they might be able to use the growing presence of the International AIDS Partnership in the district as leverage against the larger partner with whom they worked, to negotiate for further resources and more favorable working relations. And there was a feeling that the dispensaries earmarked as satellite sites would benefit hugely from International AIDS Partnership's expanded presence in the district.

Ten days after the collaborative meeting at Kaber, the district public health officer arrived at a malaria supervision meeting and announced that she had met the International AIDS Partnership program manager in the provincial capital, Kisumu. He told her that soon after the Kaber meeting, his organization and USMMR had arranged their own meeting, at which USMMR had told the International AIDS Partnership that it would not agree to allow the latter to work in the new facilities. The district public health officer lamented that their own meeting had been for nothing!

The performance of partnership as a meeting of equals with distributed responsibilities was an important tool for enabling partners to work together across disparities in the ability to

provide resources. Ultimately, the whole edifice of governance through partnership depended heavily on the success of such performances. From the perspective of my informants, the meeting between the two U.S.-funded organizations was a behind-the-scenes event that encroached on their domain of responsibility within partnership relationships. It underlined a gulf between the enactments of egalitarianism that had taken place days earlier and the difficult reality of working in a context where important decisions relating to the delivery of health resources could be made without the involvement of Kenyan government employees. The closed meeting of the two U.S. partners suggested that responsibilities for delivering HIV services were differentiated hierarchically as well as horizontally and showed that, at times, the interests of the U.S. partners could be negotiated without their Kenyan partners. From the point of view of many of the government employees, this risked turning a performance of respect and equality into a pretense.

At the time, in response to concerns from the U.S. government about possible duplication and waste of resources, agencies like USMMR and the International AIDS Partnership were coming under pressure from funders to work more closely together and to maximize "the sustainable health impact of every U.S. dollar invested in global health" by streamlining activities (CDC n.d.:6). In their private meeting, the U.S.-funded agencies appeared to be responding to concerns regarding the macrolevel distribution of PEPFAR funds. However, that meeting was perceived by the Kenyan managers as challenging their sovereign responsibility as government employees and their right to administer the organization of health resources in the district. Although partnerships were ostensibly based on a separation between support and implementation, disentangling resource allocation from decision making was not simple. Is the question of which agencies should work in which health facilities a question of implementation?

Or of support? In the fallout from the meeting at Kaber, it was easy to see why partnership relations could become strained and the district health managers sometimes appeared embattled in their attempts to defend their sovereign responsibility to deliver resources to Kenyan people.

[h1]Bridging difference

Although sovereign responsibility and the delivery of resources to citizens is understudied in contemporary anthropology, in seeking to understand the issues around difference and collaboration raised by plural and shared forms of political governance, I have found it helpful to return to an anthropological example I mention briefly in this article's introductory section. In what has become one of the most famous anthropological essays ever written, and almost certainly anthropology's most famous "meeting," Max Gluckman (1940) described the ceremonial opening of a bridge in "Zululand." The event was attended by around four hundred Zulu and 24 Europeans, including, among others, government representatives, missionaries, local chiefs, headmen, and local residents—a highly diverse group who came together under the auspices of this shared enterprise. Gluckman's extrapolation of an analysis of this "social situation" to explore broader social structures and institutions can be viewed as an early example of a mode of ethnographic description that distances itself from the task of describing static cultural institutions and instead draws attention to culture as an interactional process.

Gluckman's insights remain relevant for thinking about the meeting at Kaber and other expressions of partnership in this Kenyan context. Like Gluckman's meeting on the bridge, the meeting at Kaber was an example of a cooperative endeavor based on collaboration toward achieving a shared goal within a broader context of difference and separation. Gluckman wrote, "That Zulu and European could co-operate in the celebration at the bridge shows that they form a community with specific modes of behaviour to one another" (1940:10), and, as Ronald

Frankenberg underlined in his reanalysis of Gluckman's essay, "However much the interest of Zulu and whites, rulers and ruled, managers and managed, are opposed, they have to be seen as part of a single field of social relations" (2002:60). While a contemporary analysis would question the notion of such relations forming a single field or a social system, a key insight of Gluckman's essay remains relevant, relating to the ways differences can hold groups together. "The fundamental point that Gluckman was making was not simply that blacks and whites were part of a single social system, but that it was precisely what differentiated them from each other that was the basis for their integration" (Cocks 2001:753). Like the Zulus and Europeans who met at the bridge in the 1930s, the "partner" and "government" representatives who met at Kaber in 2011 came together through processes of differentiation that enabled their cooperation. Moreover, like that between the Zulus and Europeans, this differentiation was profoundly shaped by broader contexts of political and economic inequality.

An emerging literature on partnerships within development settings has focused primarily on the power differentials in such relationships, suggesting, for example, that "'partnership' is most commonly invoked in contexts when the more powerful party to an asymmetrical relationship feels threatened by impending hostilities and confrontation" (Gould, 2005:7; see also Abrahamsen 2004; Crane 2010; Mercer 2003). Writing about relations between the Ugandan government and the World Bank, Jon Harald Sande Lie (n.d.) has suggested that "partnership" marks out a new terrain of power in which the weaker party attempts to predict the concerns of the stronger to make the most gains from the relationship. Building on Foucault's concept of governmentality, Lie terms this new configuration of power "developmentality" and argues that, "instead of being direct and coercive, developmentality is tacit, subtle and indirect, and contingent on the donor's ability to establish a mutual complicity with the recipient through the

formation of partnership" (n.d.). In this understanding, "partnership" not only is an elaboration of new forms of coercion but also involves the development of new subject positions as each partner negotiates this terrain of power.

Identifying locations of power in partnership relations is important, but Gluckman's essay is helpful for suggesting the possibilities of a broader analysis that is as much attuned toward modalities of coming together as it is to the inequalities that shape relationships between participants. Partnership relations between the managerial team and other organizations were certainly shaped by power and resource differentials. The meeting at Kaber revealed just such inequalities. However, at the level of implementation, partnerships required actors on both sides to develop new forms of agency to manage these differences and seek desired outcomes. Both sides also resisted some aspects of these relationships, as, for example, Otieno demonstrated in his outburst at the clinic and staff at USMMR demonstrated when they became frustrated with the terms of their collaboration and went ahead with meetings without involving their Kenyan counterparts. These were forms of resistance that went far beyond mere foot-dragging (Scott 1985) and that also reconfigured, reorganized, and reallocated control of resource delivery, as actors on each side of the relationship made (sometimes conflicting) claims of managerial legitimacy. At the same time, there was genuine gratitude for the interventions of partners on the part of the ministry staff and a continual attempt to solicit new potential partner organizations to work in the district. This was perhaps the greatest irony of these arrangements; no matter how fraught relationships became, both sides deeply needed the other; without partner organizations, the District Health Management Team could not deliver basic services or fund meetings and training courses in the district. Similarly, without good collaborative relationships with the Ministry of Health, partners appeared to be rogue organizations acting without respect for local

people and context. What was ultimately most notable in the fallout from the meeting at Kaber was how little changed; the partnership carried on and both sides continued to publicly demonstrate their support and gratitude for the other. In this context, it was what fundamentally differentiated the two partners that held them together; the Americans had access to resources and the Kenyans had legitimate sovereign responsibility for Kenyan citizens. For each side of the partnership, governance without the other was impossible. These differences brought and held the partners together, structuring the form of their integration and constraining possibilities for renegotiating the terms of the relationship.

Building on Gluckman's insights, we can view partnerships both as socially dynamic forms of integration and interaction, which may be shaped by power differentials, and as modes of relating that correspond to the larger "social fields" that the participants are part of. Johanna Crane's (2010) work on scientific collaborations between U.S. universities and African institutions has analyzed partnerships to "do global health" in this way. Crane has found that when partnerships are formed in an attempt to improve health outcomes, they not only operate across power imbalances but ultimately also require the particular forms of inequality that make it possible for U.S. institutions to work in "resource-poor" settings where the undertreated bodies of African people are available for research interventions. As Crane's examples and those in this article show, studying partnership ethnographically reveals interactions shaped by power and inequalities that resonate across scales, from personal interactions to the broader structures of global aid priorities. But it is also apparent that these engagements are dynamic fields of governance, shaped at an individual level by the personalities of those involved and by the wider context of the changing landscapes of funding, institutional configurations, and global health priorities. Partnership is arguably a key institution for pluralistic and dispersed forms of

governance in the contemporary world. More specifically, the analysis of how sovereign responsibilities are organized and recalibrated through partnerships sheds light on the changing nature of transnational governance in contexts where a range of actors have overlapping stakes in the delivery of welfare.

Conclusion: The nonvanishing state

Partnerships to deliver HIV/AIDS care are a form of shared governance that is evolving in relation to changing forms of global politics. A growth in funding in global health initiatives has been accompanied by a shift from a spatial imaginary concerned primarily with national border protection and the delivery of resources to a bounded citizenry to a conceptualization of the world shaped by global trends, economic flows, and movements of people (Janes and Corbett 2009:168–169). The concerns of global health are often inextricably intertwined with issues of economic development and can be almost indistinguishable from U.S. economic and national security concerns (King 2002).

There are important precedents for forms of plural government shaped by intersecting forms of sovereignty, particularly in postcolonial contexts and other sites where the influence of the state has been tentative or partial (Das and Poole 2004; Hansen and Stepputat 2006). It is nevertheless clear that forms of governmental pluralism are both increasingly prolific and emerging in novel ways (von Benda-Beckmann et al. 2009). This is particularly true in the health sector. As in many other contexts involving forms of "transnational governmentality" (Ferguson and Gupta 2002), the partnership relations that are institutionalized in contemporary development and global health organization involve practices in which responsibilities to manage service delivery are no longer nested within hierarchical levels moving from the grassroots to the global via the regional and national. In a context where U.S. clinical research

entities can morph into "local" partners for HIV intervention and where foreign governmental agencies rent offices inside Kenyan government buildings, the spatial logics of "verticality" and "encompassment" (Ferguson and Gupta 2002) no longer suffice to explain the rationalities of power and authority at stake in many contemporary forms of governance.

Anthropological accounts of humanitarian interventions have drawn attention to the ways these endeavors are often linked to an erosion of a commitment to the welfare of citizens within a retreating neoliberal state. Certainly, the violence and cruelty of such narrowings of entitlement deserve to be exposed (Petryna 2002; Ticktin 2006). However, there is a sense in much of this literature that the changing nature of the state in these processes is so obvious that it can almost go without saying. While the failing or overwhelmed state is the taken-for-granted background for humanitarian intervention, the shrinking, retreating, neoliberal state becomes the taken-for-granted background for narrowed visions of entitlement that center on biology rather than social welfare (e.g., see Comaroff 2007; Petryna 2002). In a frequently cited essay on the politics of AIDS, for example, Jean Comaroff writes,

> [ex]It scarcely needs saying anymore that as states around the world set about outsourcing key aspects of governance, withdrawing from a politics of redistribution, the grand disciplinary institutions of the state have shrunk, or that the task of social reproduction ... has been ceded to ever more complex public-private collaborations ... under the sway of corporatized regimes of expert knowledge. [2007:199]

Yet the ethnographic evidence presented here suggests that these processes—and their relationships to emerging forms of citizenship and sovereignty—are not ones that are clearly attributable to a shrinking or vanishing state. Otieno's outburst in the dispensary and the desire of the District Health Management Team to feel and appear like a state were not suggestive of an

outsourcing of governance or of a withdrawal of the state from a politics of redistribution but reflect the importance of the sovereign responsibility of the state to supervise the delivery of resources to Kenyan people. Governance through partnership is part of the change in how governments and other organizations understand rights to manage and intervene in populations. Partnerships are shaped by a context in which the sovereign rights of the nation-state increasingly play out alongside other kinds of sovereign interest and the responsibility to manage resources is not necessarily in alignment with the ability of the state to provide them.

As Max Weber and many subsequent theorists of bureaucracy have observed, the power of modern statehood is deeply entangled with control over the processes of administering the functions and resources of the state. It is perhaps unsurprising, then, that contestations between partner organizations should manifest as a struggle for control over the material forms of administration or that forms of shared governance can raise broader concerns about sovereign influence and responsibility. In much of the global South—but also elsewhere—partnership is becoming hegemonic as a mode of governance that radically reorganizes relationships between governmental power and resource provision. At the heart of partnership constellations in the context I have described is an idealized image of the Kenyan state as the proper authority to deliver welfare services to its population.[14] A lack of resources and infrastructure is viewed as a material limitation rather than a limitation on this sovereign right to manage the ways resources are delivered to citizens. Partnership is a diagrammatic of power that relies very strongly on the notion of the bounded and sovereign nation-state. In the Kenyan case, partnership also in many respects expands the capacity of the state, as government health facilities become conduits for increased resources.

The growth of pluralistic governmental forms is changing relationships between territory, sovereignty, and the delivery of welfare entitlements to citizens. The movement of resources around the globe and the juxtaposition of different sovereign interests within partnership relations create governmental forms in which multiple actors seek to intervene within the same governmental space. In the years since the first free care and treatment programs for HIV/AIDS were initiated, the rights of HIV-positive people in Sub-Saharan Africa to receive HIV care and treatment have become widely accepted and—for now, at least—funding for this purpose is relatively secure. United by a shared desire to deliver health resources to Kenyan people, governmental and nongovernmental actors now find themselves negotiating the forms of sovereignty and responsibility that shape the possibilities for that delivery in an unequal world and playing a part within the collaborative engagements that make it possible.

[h1]Notes

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1. After the postelection violence in 2008, a coalition government came to power following international intervention and peace brokering. Many of the most important ministries were split to give key ministerial positions to people on both sides of the coalition, including the Ministry of Health, which was split into the Ministry of Public Health and Sanitation and the Ministry of Medical Services. The District Health Management Team fell under the Ministry of Public Health and Sanitation, but the hospital in which their offices were based fell under the Ministry of Medical Services. At the same time, many people continued to speak of the Ministry of Health as though there were still only one ministry, and everyone expected this arrangement to be reversed at the next election (which it was). The language in this article reflects this complex administrative situation and moves between the terms used by my informants.

2. A pseudonym.

3. One of three sites managed by the DOD in western Kenya, where various clinical trials were ongoing. At the time of fieldwork, this site was primarily involved in clinical research around malaria, including an infant vaccine trial.

4. This figure, provided by a district administrator in 2011, was extrapolated from the 2009 census on the basis of assumptions about population growth per annum.

5. In his argument, Agamben draws heavily on Carl Schmitt's (1985) discussion of sovereignty.

6. A pseudonym.

7. This term is widely used in Africanist scholarship and literature. For an example, see Livingston 2012:101–103.

8. Alongside programs initiated by the Global Fund and the World Bank at around the same time, the PEPFAR intervention represented a new commitment by the international community to raise large sums of money for HIV care and treatment in resource-poor countries, where access to antiretroviral therapy had previously been the preserve of the wealthy and well connected. See Bernstein and Sessions 2007 and Nguyen 2005.

9. For example, see U.S. Government 2009. See also Ingram 2010:610–611 and Sessions n.d. for more detail on these administrative architectures.

10. The office of the Global AIDS Programme.

11. A pseudonym.

12. The play on words is borrowed from Richard Harper's excellent (2000) essay on IMF meetings.

13. I have written about these spatial forms in detail elsewhere (Brown 2013).

14. This is a very different conceptualization of the state than was around during the period of structural adjustment and the early neoliberal period, when NGOs were supported over and above the state because the state was viewed as bloated and incapable of properly delivering resources (see, e.g., Hearn 1998; Ndegwa 1996) and is partly a reflection of the growth of the governance agenda in international development (see, e.g., Craig and Porter 2006).

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